

An Entanglement of Crises: A Symmetrical Analysis of HIV/AIDS in South Africa

By
Madeline Marcellino

Honors Thesis

Appalachian State University

Submitted to the Honors College
In partial fulfillment of the requirements for the degree of

Bachelor of Science

May 2019

Approved by:

Eric Karchmer, Ph.D., Thesis Director

Jeremiah Kitunda, Ph.D., Second Reader

Jefford Vahlbusch, Ph.D., Dean, The Honors College

Acronyms:

AIDS - Acquired Immunodeficiency Syndrome

ANC - African National Congress

ANCYL - African National Congress Youth League

ART - Antiretroviral Treatment

ARV - Antiretroviral

ARVT - Antiretroviral Treatment

AZT - Azidothymidine

HAART - Highly Active Antiretroviral Treatment

HIV - Human Immunodeficiency Virus

HOPE - Health Omnibus Program

MSF - Médecins Sans Frontières (Doctors Without Borders)

NACOSA - National AIDS Committee of South Africa

NGO - Non-Governmental Organization

NP - National Party

SANNC - South African Native National Congress

TAC - Treatment Action Campaign

TRC - Truth and Reconciliation Commission

WHO - World Health Organization

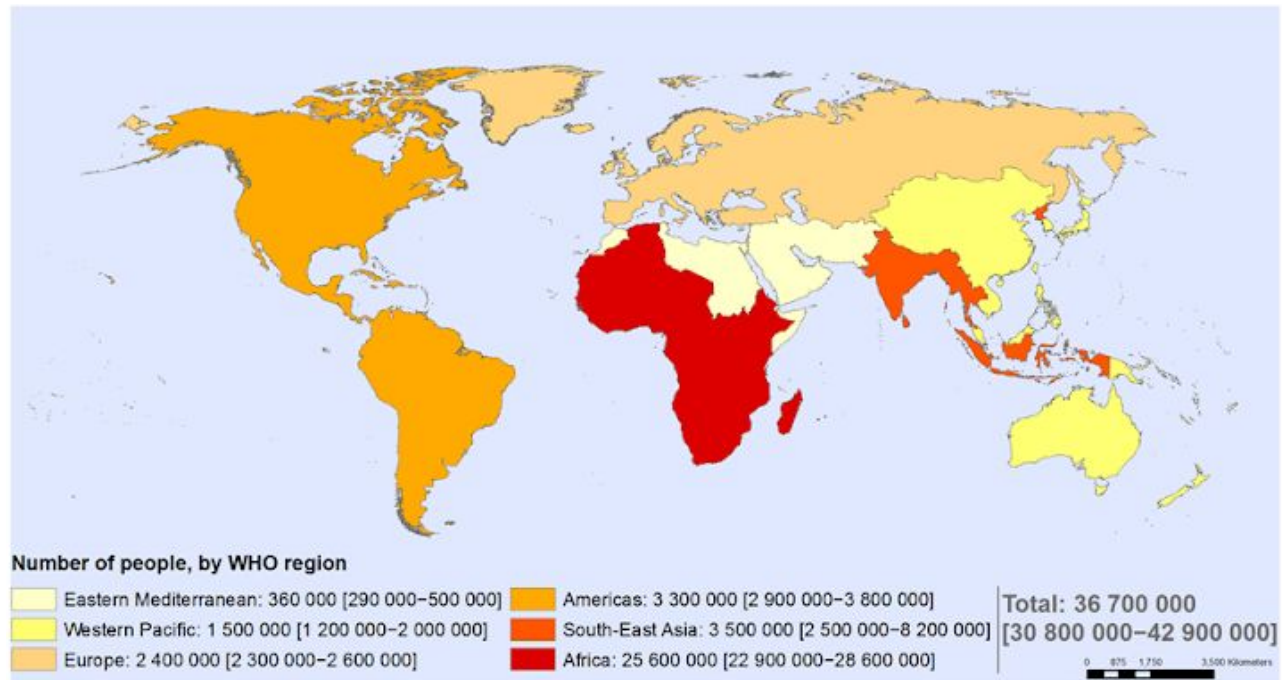


Figure 1. Global Distribution of People Living with HIV/AIDS in 2016. (WHO 2018)

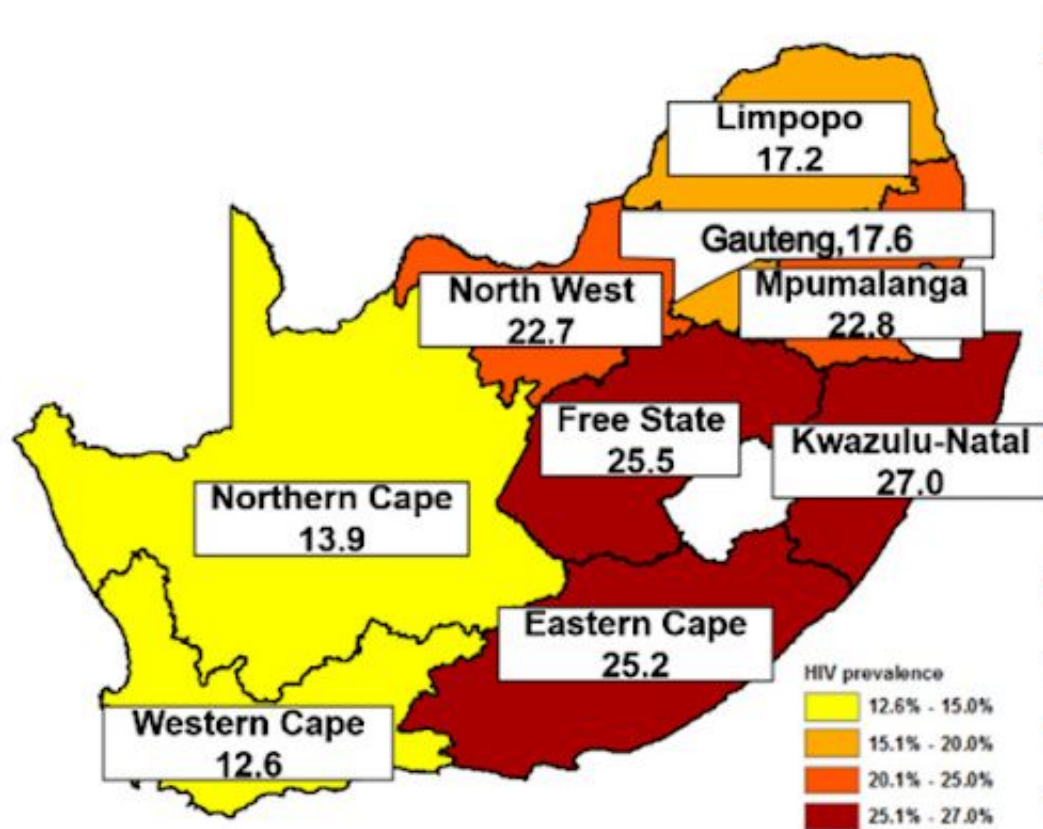


Figure 2. Map of South African Provinces by HIV Prevalence among Adults in 2018 (ages 15-49) (Human Sciences Research Council 2018)

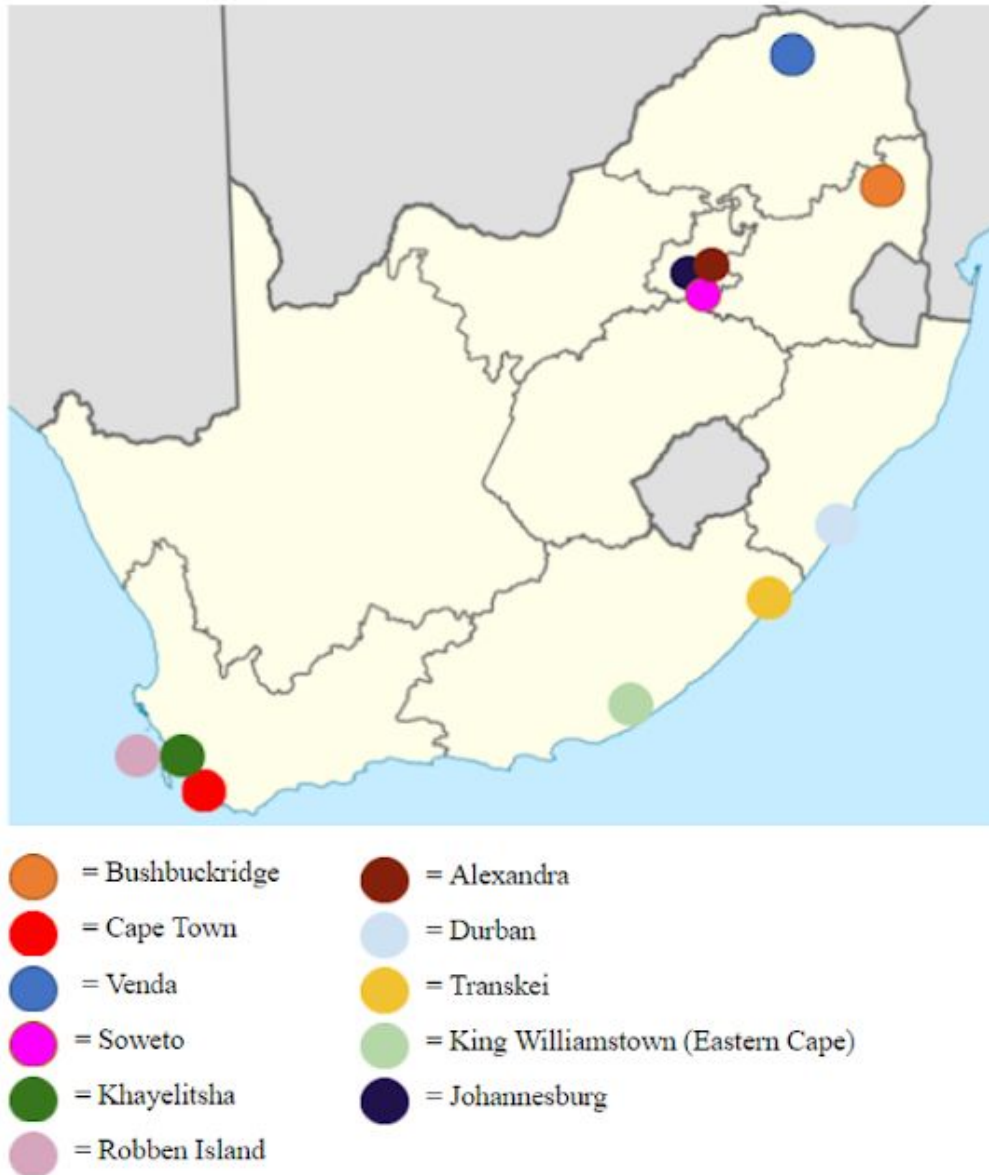


Figure 3. Referenced Ethnographic Field Sites

Abstract

This thesis provides a symmetrical analysis of HIV/AIDS in South Africa. Divergent realities of disease illustrate the existence of synchronic crises: the HIV/AIDS epidemic and the social crisis. I argue that these crises cannot be understood independently. The social crisis stems from historical trauma and continues through structural violence. The orientation of this thesis lays in ethnography and history. Global Health, as a universalizing paradigm, fails to account for local realities. Local accounts of biomedicine, witchcraft and traditional healing will be analyzed in order to illustrate their entanglements, and subsequent impacts on the HIV/AIDS epidemic.

Introduction

The Republic of South Africa faces two synchronous crises. The first is the human immunodeficiency virus and acquired immunodeficiency syndrome (HIV/AIDS) epidemic. South Africa is the site of the world's largest HIV/AIDS epidemic; approximately seven and a half million South Africans were HIV-positive in 2018. It is also home to the largest national antiretroviral treatment (ART) program as about four and a half million South Africans are receiving antiretroviral therapy (ART) (Avert 2019). Drugs were made publicly available in 2004, yet, thirteen years later, there were approximately 270,000 new HIV infections and 110,000 AIDS-related deaths (Avert 2019). Figure 4 illustrates such trends from 2002 to 2018. The second is the social crisis. This crisis is found in the trails of associations between existing institutions (i.e. politics, health, religion, economics, etc.) (Nading 2014; Latour 1993). It results from lingering structures of the nation's past. The social crisis escalated in the transition from a white-minority-ruled Apartheid government to the post-apartheid black-majority-rule republic. These crises exist as entanglements in South Africa, as disease affects the social realm and social disparities influence the epidemic.

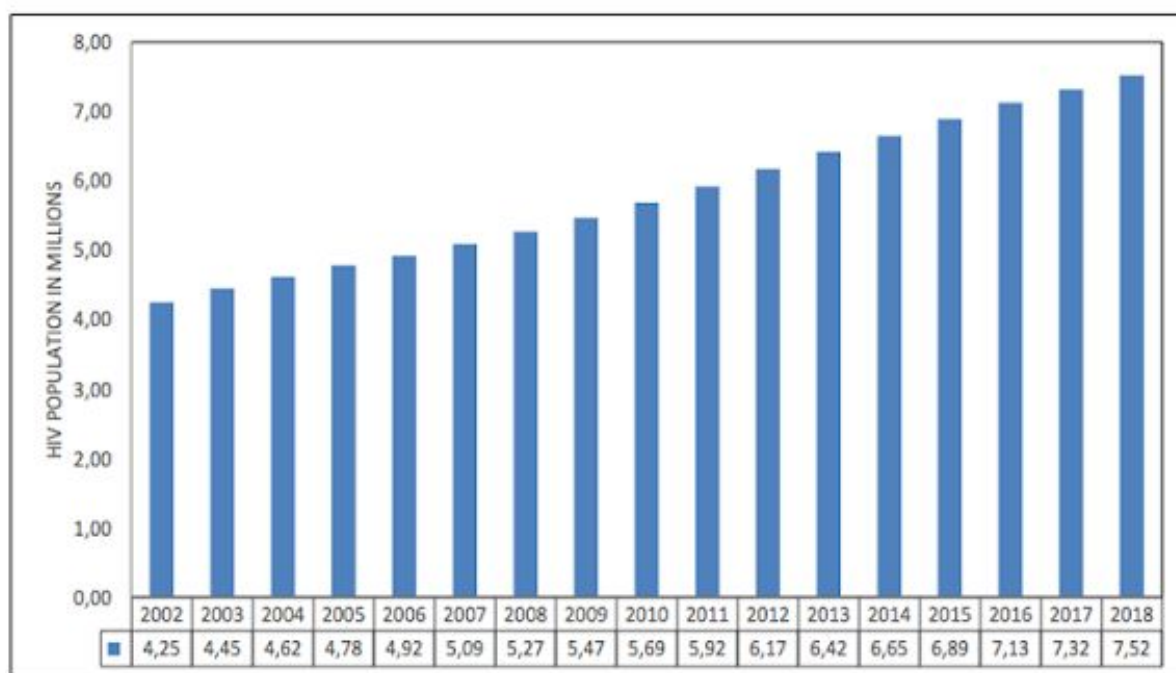
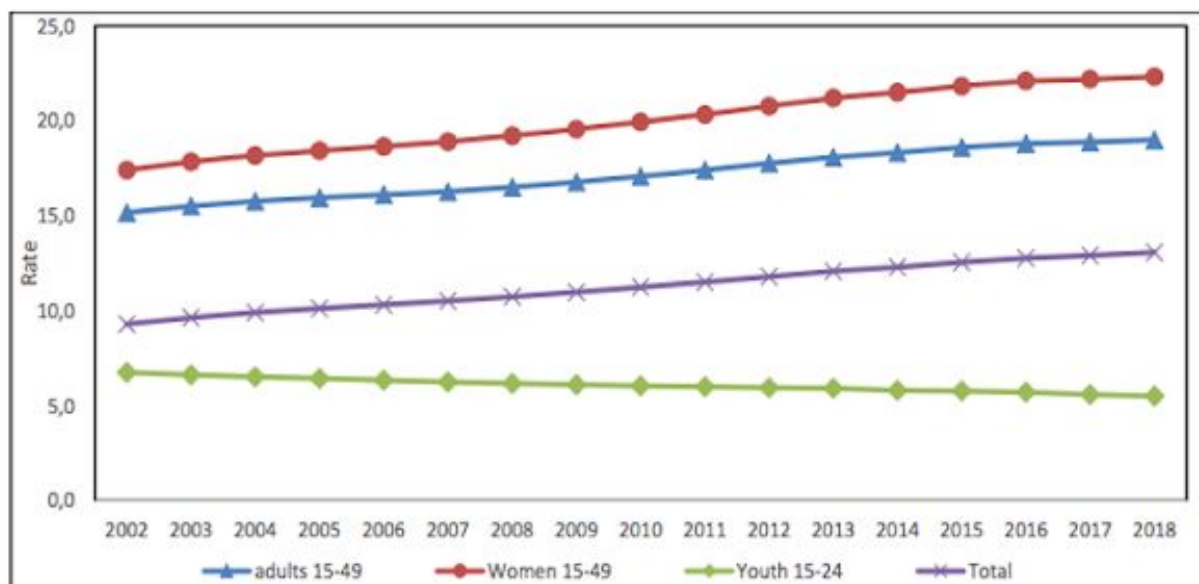


Figure 4. HIV population statistics in South Africa from 2002-2018. A) HIV prevalence by age group. B) HIV population in millions (SA National Planning Commission 2018)

These two crises are currently viewed independently. This dichotomy results in insufficient HIV/AIDS treatment (and prevention) programs. The social crisis and HIV/AIDS epidemic must be deconstructed in order to build more effective programs reflective of their entanglements. Implementation of Bruno Latour's concept of natures-cultures provides a theoretical framework from which my position is formed (1993).

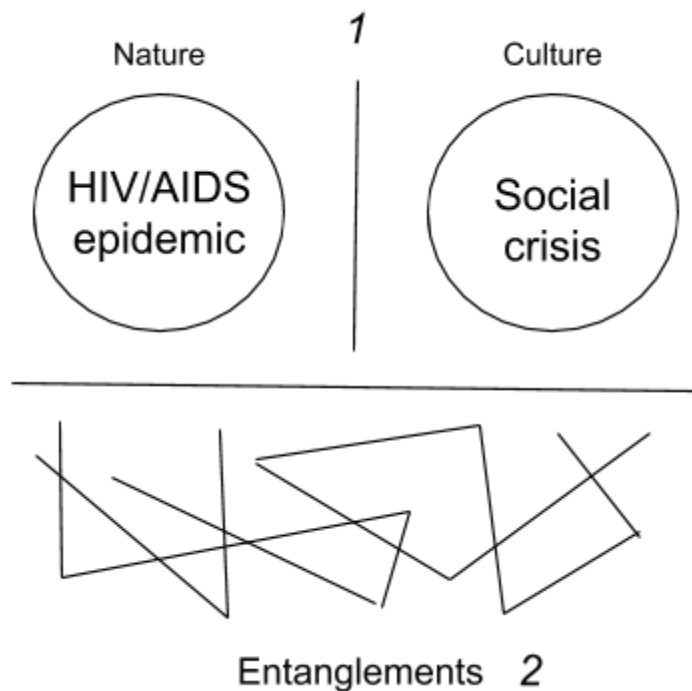


Figure 5. Latourian Great Divide in Context. 1) Purification. 2) Translation (Latour 1993)

The Internal Divide, 1 in Figure 5, situates nature and culture as independent spheres. This dichotomy seeks an absolutism that does not exist. Latour describes this as *purification* (1993, 11). The HIV/AIDS epidemic is purified by Global Health, as it is situated as scientific fact. In contrast to such othering, Latour's notion of *translation* situates various institutions in terms of their entanglements (1993; Figure 5, 2). These networks situate nature and culture as hybrid elements that are, and always have been, interrelated. It is therefore in these networks that

the HIV/AIDS epidemic must be understood. There are only natures-cultures. The HIV/AIDS epidemic only exists in relation to the social crisis. Therefore, it cannot be understood in isolation.

This thesis will analyze local realities in order to illustrate the entanglements of natures-cultures. It will probe such questions as: Why are South Africans still becoming infected with HIV at such high rates? Why, with the world's largest ART program, does the epidemic continue to grow? In order to answer these questions I will first provide a historical overview. These origins illustrate the entanglements between health and social by comparing global health discourse and local realities.

A Historical Overview of South Africa

The Dutch stopped on the South African coast on their routes to the West Indies. Upon forming a permanent colony in what is now Cape Town (the Cape colony) beginning in 1652, they forcibly removed countless indigenous people. They imported slaves from Indonesia, India, and Eastern Africa, who alongside native workers and their white owners, made up the new infrastructure of the colony (Pretorius 2011).

Responding to the French annexation of the Netherlands, Britain sought control over the Cape Colony in order to secure the route to the West Indies. With a larger and more technologically advanced army than their Dutch and African counterparts, the British asserted their dominance in the region. African polities faced considerable hardships in response to violent altercations with the British. Resulting casualties, in regards to both men and land, left African communities dependent on the Europeans for sustenance (often through cheap employment). In a campaign of so-called humanitarianism, Britain abolished slavery in the

colony in 1834 (Ross 1999). Angered Dutch settlers, dependent on the slave labor, responded with the infamous episode called the Great Trek, in which they moved inland. These migrants, seeking independence from British rule, were to be later known as Afrikaners (Pretorius 2011).

The systematic racism originating in these early colonial power structures was re-legitimized with the implementation of Apartheid, following the rise of the National Party (NP) in 1948. At this time, South Africa was a nation-state, an self-governing body within the British Empire. The NP was a conservative political party that aimed to promote the Afrikaans culture. Apartheid was a system of separation by race and ethnicity; it's implementation made the oppression already present within the South African borders official by law. Families were broken; education and employment were limited; non-white people were unjustly imprisoned and killed. The scenes of apartheid reflect slavery. Mr. Ali, an elderly man living in the Riverlea Extension township of Soweto, describes living under Apartheid:

It's the apartheid, Missus. They dump you here and forget about you. They don't build enough houses. Most of us in Extension could afford the rents in Riverlea, Bosmont, other places, but there aren't enough houses. They won't let us buy this rubbish, so we're afraid to make improvements in case they kick us out. But they won't fix anything, and they give us no electricity, no water, no heating. I have to read the newspaper by candlelight. It's unhealthy: the lavatories are always broken. It stinks here. It's apartheid, Missus. That put my here, that keeps me here. (Levine 225)

Evident in Mr. Ali's description, black South Africans experienced deliberate subjugation by the NP. Levine relates this period of South African history to that of Nazi Germany (2015). People deemed useful were enslaved while the others were left to perish with inadequate housing, an insufficient food supply, and no opportunity for progress (Levine 2015). The ability to resist such a harsh system was debated in townships throughout the nation. As the domination of the NP

intensified, the amount of resistance groups grew. The non-white population faced these harsh, often inhumane, policies until the end of the twentieth century.

The African National Congress (ANC), originally founded as the South African Native National Congress (SANNC) in 1912, was the first significant opposition movement to racial inequality (Lucas, 2018). There were three major phases of resistance within the ANC: dialogue, direct opposition, and armed struggle (South African History Online 2016). Within the general body of the ANC, Nelson Mandela, Oliver Tambo, Ashby Mda, and Walter Sisulu, created the ANC Youth League (ANCYL) in 1944. The aim of this sub-organization was to mobilize youth in the fight for freedom. The ANCYL was grounded in taking action. The preamble of its original manifesto discusses its goals:

Whereas Africanism must be promoted i.e. Africans must struggle for development, progress and national liberation so as to occupy their rightful and honourable place among nations of the world;

And whereas African Youth must be united, consolidated, trained and disciplined because from their ranks future leaders will be recruited; And whereas a resolution was passed by the conference of the African National Congress held in Bloemfontein in 1943, authorising the founding and establishment of the Congress Youth League;

We therefore assume the responsibility of laying the foundations of the said Youth League. (*ANC Youth League Manifesto*)

The role of youth resistance was pivotal in the fight against Apartheid. Aligning with the ideals of the ANCYL, students in Soweto protested the mandated use of Afrikaans in their schools.

During the Soweto Uprising of 1976, police opened fire into the crowd of unarmed black students. It gained massive amounts of international attention and initiated numerous movements across the nation. This moment situated youth activism as a major element in South African society (Heffernan and Nieftagodien 2016).

The leadership role of Nelson Mandela was another major contribution to the fight against apartheid. In response to the increasing acts of violence by the NP, Mandela co-founded the Spear of the Nation, the armed section of the ANC. Mandela justified this shift in methodology, from peace to violence:

At the beginning of June 1961, after a long and anxious assessment of the South African situation, I, and some colleagues, came to the conclusion that as violence in this country was inevitable, it would be unrealistic and wrong for African leaders to continue preaching peace and non-violence at a time when the Government met our peaceful demands with force. This conclusion was not easily arrived at. It was only when all else had failed, when all channels of peaceful protest had been barred to us, that the decision was made to embark on violent forms of political struggle, and to form Umkhonto we Sizwe. We did so not because we desired such a course, but solely because the Government had left us with no other choice. (Mandela)

Working to achieve racial equality and justice, Mandela faced trial for treason and sabotage. In a speech outside the Palace of Justice, he defended his actions and recounted the importance of freedom:

During my lifetime... I have cherished the ideal of a democratic and free society in which all persons live together in harmony and with equal opportunities. It is an ideal which I hope to live for and to achieve. But if needs be, it is an ideal for which I am prepared to die. (Mandela)

Mandela's devotion contributed to his emergence as a national icon. He symbolized hope, justice, equality, and reconciliation (Niehaus 2013; Obama 2013).

After imprisonment for twenty-seven years, Mandela was elected as the first black President of South Africa (1994-1999). The main objectives of his presidency were: to oversee the political transition into an integrated democracy, to improve the crashing economy, and to create a new image for South Africa (History.com editors 2009). This proved to be a complicated transition as the structural inequalities of the past continued to prevail. Inadequate housing,

fractured families, poor education systems, and severe unemployment are a few of the many hardships this new nation faced.

Proper housing can serve as protection and privacy; it is a space in which a person can assert their independence (Turok and Borel-Saladin 2016). The arrangement of housing influences the economy and social coalescence. On the contrary, adverse housing conditions can further present inequality. The rapid growth in urban areas after apartheid, placed increased pressure on housing reform. Policies by the ANC provided more than two million houses to those in need. However, this allotment was insufficient as millions remained homeless, and those homes built were often poorly constructed and associated with corruption. In response to the government's failure, civil society took matters into their own hands. One example of this is seen in the proliferation of backyard shacks. These shacks, technically illegal, were dismissed by the government, and not accounted for in analysis and reform (Turok and Borel-Saladin 2016). The ANC failed to see how their program affected the local scene. The creation of houses by the number, seen by the ANC as effective, failed to recognize the additional factors that played a part in this housing disaster.

Unemployment was a socio-economic factor neglected in housing reform. In 2018, South Africa's unemployment rate was 27.1% (Kekana 2019). This historical overview discussed the dependencies of the colonial South Africa's economy: slave labor from the onset of Dutch colonization, cheap labor from vulnerable native polities after British colonization, and poverty-level rates from the subjugated black population under Apartheid. The political transition to majority rule meant that the workforce that was once controlled by a minority

population was now overflowing. The rate of job creation was severely insufficient for the large amount of people seeking jobs (Kekana 2019).

This high unemployment has been described as a “fertile ground for the increase in the rate of crime and lawlessness” (Twalo 2010, 845). The violence of Apartheid was gruesome. Instances of torture, unwarranted detention, and random murders were common. Violence remains a major issue in modern South Africa. Bheki Cele, South Africa’s Police Minister, compares modern South Africa to a warzone. The murder rate, which is growing, was 35.8 per 100,000 people in 2017; this placed South Africa as the country with the fifth highest murder rate in the world (Reality Check Team 2018). Crimes against women is also high in South Africa. Mogale et al. tell the story of a woman named Buyisiwe, who was gang raped (2012). In addition to the trauma of the attack, Buyisiwe experienced ridicule in the court as she was forced to reenact her experience, providing details (as if it was a test) to the court in order to prove that her claim was valid (Mogale et al. 2012). Naidou states, “One in two woman are predicted to experience some form of violence within their lifetimes” in South Africa (n.d.). Political measures enacted to diminish violence against women are often deemed inadequate as they fail to recognize contributing factors to such actions, such as traditional patriarchal values.

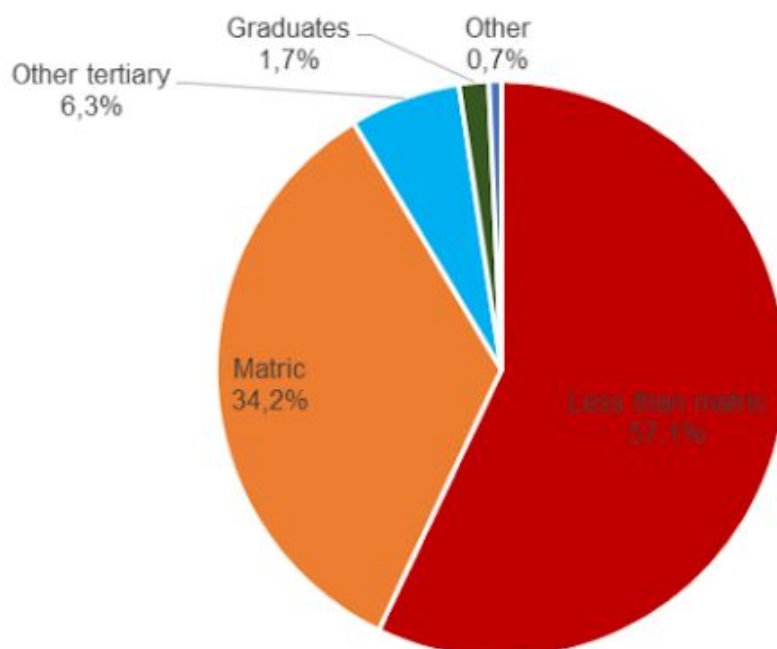


Figure 6. Rates of Unemployment in South Africa by Education Level. (South Africa Public and Media Relations 2019)

The majority of those unemployed have minimal education, as shown in Figure 6. The Bantu Education Act of 1953 created a public education system that was separate and unequal. Designated schools for black children followed a curriculum that reinforced the hegemonic control by the NP. “Ideological manipulation” (Christie and Collins 1982, 60) depicted African people, and culture, as inferior to Afrikaners. Black children were conditioned for a life in servitude as this education system prepared them to serve society in often demeaning roles deemed appropriate by the racist NP (Christie and Collins 1982). This degrading education of the past contributes to modern issues. Today’s pressures to achieve high levels of education often results in guilt, low self-esteem, and inadequate training in skills-related jobs (Christie and Collins 1982). This often alienates those that are not successful in climbing the education ladder.

The underlying structures of colonialism and Apartheid continue to prevail as they live through present social issues, as described above. This structural violence embodies the social crisis as “historically given (and often economically driven) processes and forces that conspire [...] to constrain agency” (Farmer 2003, 40) flourish. The violence of the past has diffused and transformed, working behind the scenes to prolong its disruption. Along with this social crisis, the HIV/AIDS epidemic presented an immense postapartheid challenge.

History of HIV/AIDS: South Africa in an International Context

The HIV/AIDS epidemic grew alongside these monumental political transformations. The first HIV diagnosis in South Africa was in 1982 (Avert 2019). Response to the disease was slow and often capricious. While the amount of South Africans with HIV increased, predominantly among the black population, the NP response remained minimal. Health policies only emerged to maintain a cheap labor source (IJsselmuiden et al. 1993). The ANC officially recognized the need to combat the AIDS epidemic in 1991, drafting a preliminary program and, along with other political parties, created the National AIDS Committee of South Africa (NACOSA). These initial measures were created in good intent but failed due to insufficient infrastructure for implementation and unstable political conditions.

Achieving democratic freedom in 1994, a decade after the emergence of the disease, non-white South Africans entered the global discussion on HIV/AIDS with a temporal disadvantage. At the beginning of the HIV/AIDS epidemic, the 1980s, dominant western discourse associated the disease with drug users, sex workers, and homosexual males. This resulted in the initial stigmatization of the disease. Attention to the disease increased as a result of early HIV/AIDS activism. These initial collectives were made up of young adults infected

with HIV (Powers 2017). The World Health Organization (WHO) held the first international meeting on the HIV pandemic in 1982. Five years later, the WHO established the Global Program on AIDS and the Federal Drug Administration (USA) approved the first antiretroviral drug to treat HIV, azidothymidine (AZT). International standards outlined a global health, largely through the implementation of biomedical understandings of the disease, response to the epidemic (The AIDS Institute 2011). These advancements occurred while South Africans were still fighting for basic human rights. The advent of Highly Active Antiretroviral Treatment (HAART) in 1995 further advanced the western paradigm of the AIDS epidemic. Mandela's administration made little progress in regards to diminishing the progress of the disease in South Africa (Ngcaweni 2016). These policies failed due to inadequate infrastructure and scarce national focus.

South African HIV/AIDS activism peaked in 1998 with the emergence of the Treatment Action Campaign (TAC). Zackie Achmat, along with a small group of HIV-positive South Africans, protested in demand of drug access, in response to the death of AIDS activist, Simon Nkoli. TAC, along with other HIV/AIDS advocacy groups, called for political involvement, and heightened discussions on the role of the government in healthcare (Treatment Action Campaign n.d.). President Thabo Mbeki (1999-2008) was elected amid this growing advocacy. Rates of HIV grew from less than 1% to 23% in the decade prior thus furthering the support for Mbeki to act on the disease (Karim and Karim 2002). Mbeki was a controversial figure in the HIV/AIDS epidemic as he publicly denounced the association between HIV and AIDS. He believed that HIV, with the support of a few scientists across the globe, was a minimally effective retrovirus incapable of causing such a syndrome as AIDS (Kalichman et al. 2010). Although these claims

were quickly disputed by the majority of the scientific community, President Mbeki used them as support. He separated Western AIDS and South African AIDS; this distinction arose from both scientific and political bases. Drawing from the notion that HIV does not lead to AIDS, Mbeki believed that AIDS in South Africa emerged from various social inequalities. These mainly referred to malnutrition and additional effects of poverty (Mbeki 1998). The health department in his administration also promoted adequate diets as AIDS prevention.

The separation of AIDS by region tied to Mbeki's desire to establish South Africa as an independent, and self-sufficient, nation. He describes this notion as the African Renaissance:

The African Renaissance, in all its parts, can only succeed if its aims and objectives are defined by the Africans themselves, if its programmes are designed by ourselves and if we take responsibility for the success or failure of our policies. (Mbeki)

This concept, in application to HIV/AIDS, denied the benefits of biomedicine because it was seen as 'foreign.' While biomedical discourse often blamed AIDS victims for their disease, as it was highly associated with sexual promiscuity, poverty as the cause of AIDS shifted the blame to the European colonizers that initiated the economic disparity. As shown in Figure 6, HIV was more prevalent among those with lesser incomes. The correlation between poverty and HIV/AIDS is unignorable, but this ignorance of alternative understandings contributed to countless savable deaths by AIDS (Thomas 2013).

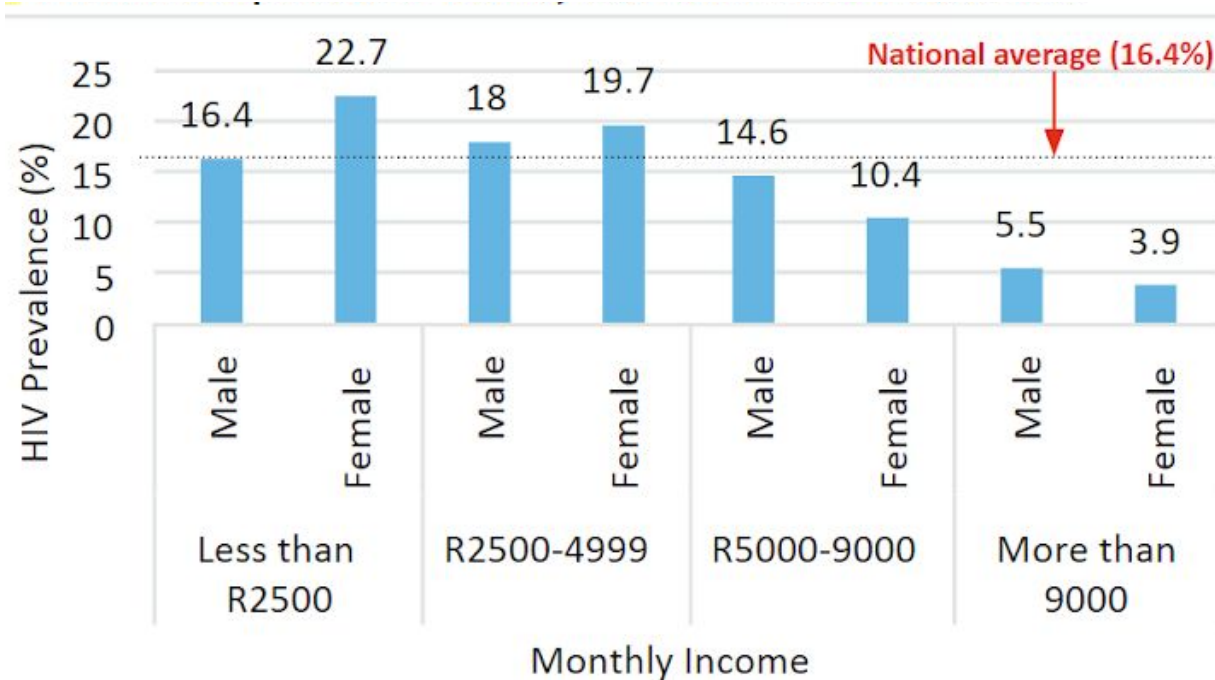


Figure 6. Prevalence of HIV by Monthly Income in South African rands. (Ngcaweni 2016)

TAC grew under Mbeki's denialism, transforming into a major South African NGO. It implemented its apartheid-roots through its awareness discourse.

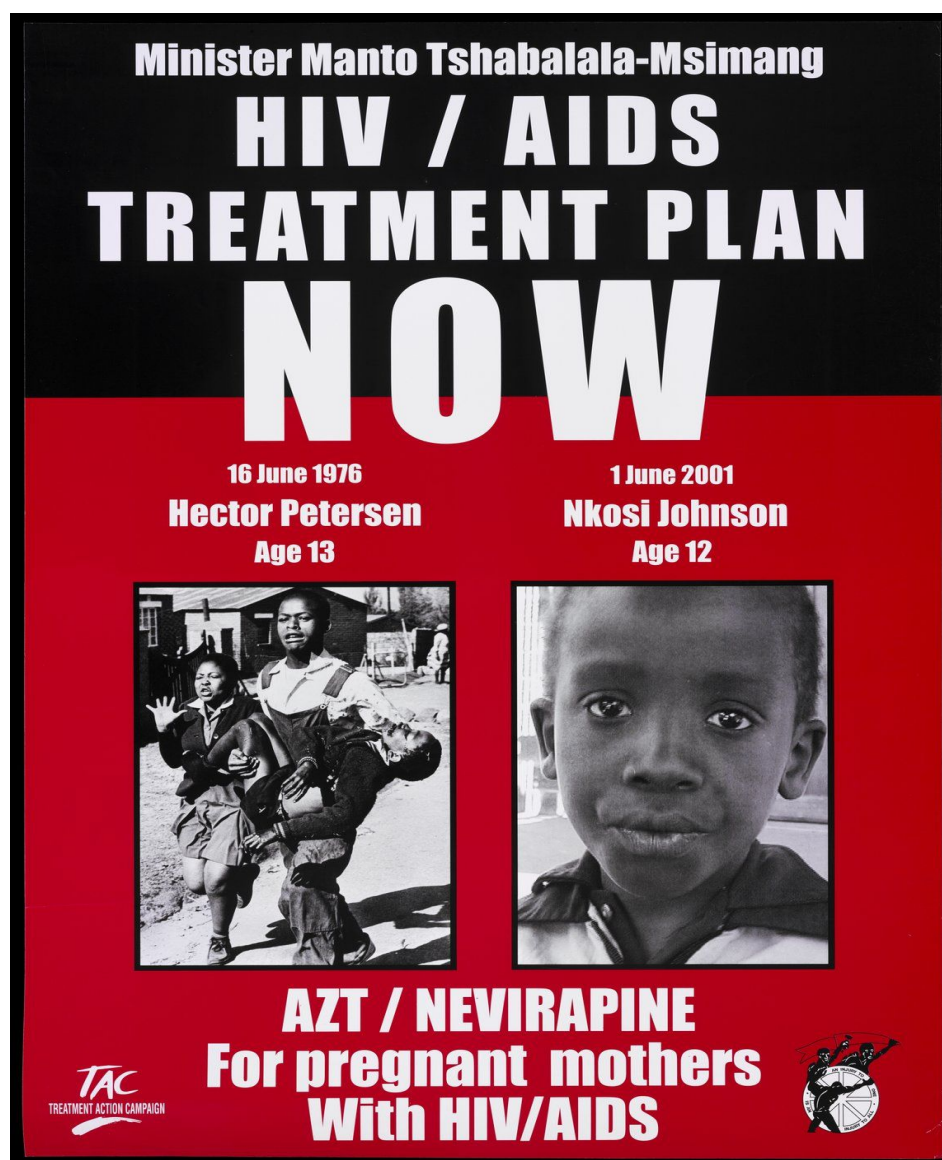


Figure 7. TAC Awareness Campaign with Hector Peterson and Nkosi Johnson

The nation's historical trauma served as a tool to mobilize a collective front. A flyer with Nkosi Johnson, an eleven year old with HIV transmitted from his mother at birth, and Hector Peterson, a twelve year old killed in the Soweto Uprising, illustrates this discourse (Figure 7). The timing of TAC involvement dramatically influenced its take on the disease, as its initial movements involved awareness campaigns and protests for drug distribution - products of Global Health.

Powers explains how TAC aligns with the Global Health paradigm as it “activated networks of international solidarity” (2017, 38).

It is evident that numerous factors contribute to the HIV/AIDS epidemic and social crisis in South Africa. Local realities influence the implementation of social reform and medical treatment. Ethnographic material can deconstruct the crises in order to reveal their entanglements. Socio-cultural injustices and biological deficiencies currently exist in a parasitic relationship. Recognizing the hybridity of Latour’s natures-cultures can resituate this relationship between the crises, enhancing reform.

The Application of Global Health

Global health has been profoundly shaped by the HIV/AIDS epidemic. In turn, it has developed a particular linear understanding that relates HIV, AIDS, and ARVs. The goal of this paradigm is to improve the health of populations across the world; it often implements humanitarianism as it seeks to prolong life (Redfield 2013). Developments in this field have saved millions of lives, as rates of mother to child transmission drop, and life expectancy of people with HIV rises (Packard 2016). However, it has numerous inadequacies stemming from its claims of universal applicability. This thesis shows how global health programs are inadequate in the South African HIV/AIDS epidemic as a result of its disregard for unique local realities. It is too narrow to account for variation and too rigid to recognize the coinciding social crisis.

The primary discourse of global health is biomedicine- a practice of medicine that regards biological evidence as truth. Biomedical interventions work from the basis that HIV, which is transmitted through “blood, semen, pre-seminal fluid, rectal fluids, vaginal fluids, and

breast milk” (U.S. Dept. of Health and Human Services n.d.), causes AIDS. Pharmaceutical drugs are common to biomedical practices as they emerge from the natural sciences. The creation of ARVs to treat HIV was groundbreaking in global AIDS pandemic. These drugs not only make it possible to live with the virus, but also diminish the chances of transmission. Success of global health application is quantitatively measured; numbers replace people (Biehl and Petryna 2013).

Visibility and Invisibility: The Limitations of Biomedical Technologies

One focus of biomedicine is the centrality of visibility; diseases are made visible through various technologies (Foucault 2003). According to Alice Street, “With the emergence of pathological anatomy came a new kind of gaze that penetrated the body and saw into its depth. Disease become localizable in and specific to the individual body” (2014, 14). Street discusses how X-rays act as means of attaining visibility at the Madang Hospital in Papua New Guinea (2014). Capturing biological abnormality at a specific moment in time, X-rays are evidence. Similarly, the HIV test is a way to render the disease visible to both the patient and administration. It transforms a person into a victim by analyzing T-cells (CD4 count) to form a diagnosis.

The administration of former South African President, Jacob Zuma (2009-2014), sought to increase HIV testing by issuing a national testing campaign (Ngcaweni 2016). In his speech on Global AIDS Day in 2009, President Zuma said: “To take our response a step forward, we are launching a massive campaign to mobilise all South Africans to get tested for HIV. Every South African should know his or her HIV status” (Ngcaweni 2016). In this, test results are seen as means to an end. It was expected that knowledge of one’s status aligned with seeking necessary

treatment. President Zuma hoped that collective testing would diminish the stigma. Studies, however, show that to test positive for HIV, was to accept the associated guilt, blame, and stigma (Niehaus 2013; Stadler 2003; Ashforth 2002). The national campaign also emphasized personal responsibility as Zuma announced:

All South Africans should take steps to ensure that they do not become infected, that they do not infect others and that they know their status. Each individual must take responsibility for protection against HIV. To the youth, the future belongs to you. Be responsible and do not expose yourself to risks. Parents and heads of households, let us be open with our children and educate them about HIV and how to prevent it. (Ngcaweni)

This claim neglects to account for historical trauma as it assumed that the spread of HIV rests in the decisions of present individuals rather than in past afflictions. For example, Zuma fails to connect the poor economic infrastructure and subsequent unemployment rates to the men and women working in the sex industry. These sex workers experience high rates of HIV but believe their responsibility often lay elsewhere, such as to provide for their families (Avert 2018). The risk of disease is diminished in such a perspective. The rights of workers in this industry are also limited as attempts at protection can be violently refused, or result in less work. These elements are part of the present social crisis, often neglected in statistics that rely on filed reports, in South Africa, and ought to be recognized in HIV/AIDS discourse.

Access to visibility is a way in which global health practices biopower. Biopower is “an explosion of numerous and diverse techniques for achieving the subjugations of bodies and the control of populations” (Foucault 140, 1926). It often results in the neglect of individual autonomy as people are reduced to bodies in terms of biological disease (Nguyen 2010).

Testing and ARTs have numerous benefits. As they act to prolong life and fight HIV, they often work at the line between life and death. This renders them mystical. Patients on ART

can transform from skin and bones on the brink of death to healthy individuals living normal lives (*The Age of AIDS* 2006). This mystic ability often raised suspicion as drugs worked through invisible pathways. The inability to see the pathway in which both the virus and drugs travel leads to ambiguity, or a gap to be filled with alternative discourse. Viruses cannot be seen by the invisible eye, making their existence, and supposed transmission, murky. Numerous unknowns remain after achieving biomedical visibility; it is always incomplete.

In spaces of such invisibility, alternative discourses flourish. Witchcraft, for example, flourishes in the visible and invisible. Isak Niehaus states that “witchcraft is invisible and witches cannot be known in themselves or in terms of their internal attributes... they are known through their deeds, and through their actions upon the natural and social world” (2013, 95). The limitations of biomedicine, such as this resulting invisibility, must be assessed in order to transform its practice in the South African HIV/AIDS epidemic into one that encompasses various existing realities.

Visual Discourses: Murals as Awareness Campaigns

The application of universal discourse, such as global health and biomedicine, is often too broad to be effectively applied in local contexts. Awareness campaigns, developed in the west, used murals to reach wide audiences. Applied in public spaces, using local artists, these visual discourses drew assumptions about community beliefs. Working with visibility as a prevention technique, these discourses again fail to recognize the invisible elements contributing to the epidemic.



Figure 8. Mural in King Williamstown, 1997. (Marschall 2004)

A mural, painted in the Eastern Cape in 1997, illustrates skeletons moving towards engulfing flames (Figure 8). The artwork portrays the fate of those infected by HIV. This visual discourse framed HIV as a disease without hope (Marschall 2004). Fear was often used in an attempt to “prompt a change of behavior by showing reality of those suffering and dying from AIDS” (Marschall 2004, 168). This method fails to account for situational behavior. Instances of drug use and sex-work, as discussed prior, can surpass these prompts on the basis on psychological, social or economic needs. The fear that lie among such biomedical discourses furthered its separation from certain, already marginalized, communities.

Depicting the reality of AIDS, prior to drug access, as death, reflects the humanitarian aims of global health. Peter Redfield discusses this practice as biomedicine ceases to exist beyond life (2013). Universal values, in regards to life and death, are assumed based on western

values. Conceptions of an afterlife are omitted. This biomedical negligence can be filled with witchcraft and religious discourse, as the continued influence of ancestors connects the dead and living.

Visual Discourses: Body Maps in Khayelitsha

Numerous awareness campaigns were created in South Africa. In Khayelitsha (township outside of Cape Town), Doctors Without Borders (MSF) and TAC implemented the Memory Box Project to have HIV-positive women depict their illness experience through body maps (Thomas 2013; Morgan 2003). The Memory Box Project was a result of an experimental ARV program that began in 2001. The initial treatment program transformed into a nationally renowned movement that “rejuvenated a sense of activism and engagement beyond its specific project sites” (Redfield 2013, 278). The creation of body maps was meant to serve as treatment for the artists, and awareness for the public. Individualizing visual discourse, body maps were personal interpretations of illness experiences.

Body maps, as they were created within the context of biomedicine, can be analyzed to illustrate the intersection of biomedical and lay discourses of HIV/AIDS. They “provide a way to navigate the social and biomedical aspects of the lives of women who made them [...] as sites of truth through which the subject of the body can be made known” (Thomas 2013, 14). Kylie Thomas argues that these illness narratives are able to empower women; they can combat the sexual inequality rampant in society (2013). Ethnographic material from this site provides material to address how numerous women depict the application of biomedicine in a local setting.



Figure 9. Bongiwe's body map (Morgan 2013)

The first woman discussed is Bongiwe. In her body map, a bible lay next to her head to represent relationship with the church (Figure 9); Bongiwe says that she often thinks about the bible (Morgan 2003, 103). The large green object near her chest is a protea flower: “This flower means a lot to me. It represent my country S.A. which I love very much. It is my mother country (land)” (Morgan 2003, 103). This love for her country rests in her heart, suggesting the great value she places on South Africa. Her body is thus connected to place. Bongiwe next describes the physical scars depicted in the portrait. These scars are the results of beatings, accidents, and a rape. Her story reflects the high rates of violence towards women in South Africa (SA National Planning Commission 2018). Her body is now situated in regards its connections with perpetrators of such crimes. In ethnographic work in Durban, Campbell et al. found that “many informants spoke of the way in which the weakness of women had fueled the epidemic” (2005, 810). The intersection of violence and disease is illustrated in this body map, and described in Bongiwe’s stories (Morgan 2003). Her story connects her drawn body to various social entanglements.

There are several references to HIV in Bongiwe’s portrait. The fire at her feet symbolizes HIV: “In my picture the HIV looks like fire because I felt that it was like something burning inside because I had lots of pains in my body” (Morgan 2013, 107). Bongiwe describes how this fire burns inside of her, indicating that the disease rests within her own self. It is seen in isolation of the sexual networks of transmission. This contrasts to the numerous social ties she previously discussed.

The miniature body, labeled “46 kg,” represents Bongiwe’s physical appearance when suffering from HIV without medication. An altered outward appearance is often associated with

misfortune- whether social or biological. When her mother's physical appearance began to degrade, Bongiwe became suspicious of her HIV status. Her mother never revealed her HIV status, Bongiwe only found out after accompanying her to the doctor when she became too weak to move on her own.

This small person inside my stomach, it's me. This picture shows me when I started using ARVs. I was small and so tiny. I was weighing 46 kilograms. It was March this year. Then I started using ARVs and I gained a lot of weight. I have improved a lot. I am weighing 58 kilograms now. So this big body around the small body is me now (Morgan 106).

Thomas notes that “the emaciated body that was hers prior to gaining access to treatment has not been swallowed up by time and forgotten but is shown as living on inside the larger figure of her healthy self” (2013, 22). The ARV treatment, in the lens of global health, would be classified as successful as it restores Bongiwe's healthy body (and CD4 count). This technical view neglects the continued suffering that is made evident by the inclusion of her past self, and the fire, in this portrait.

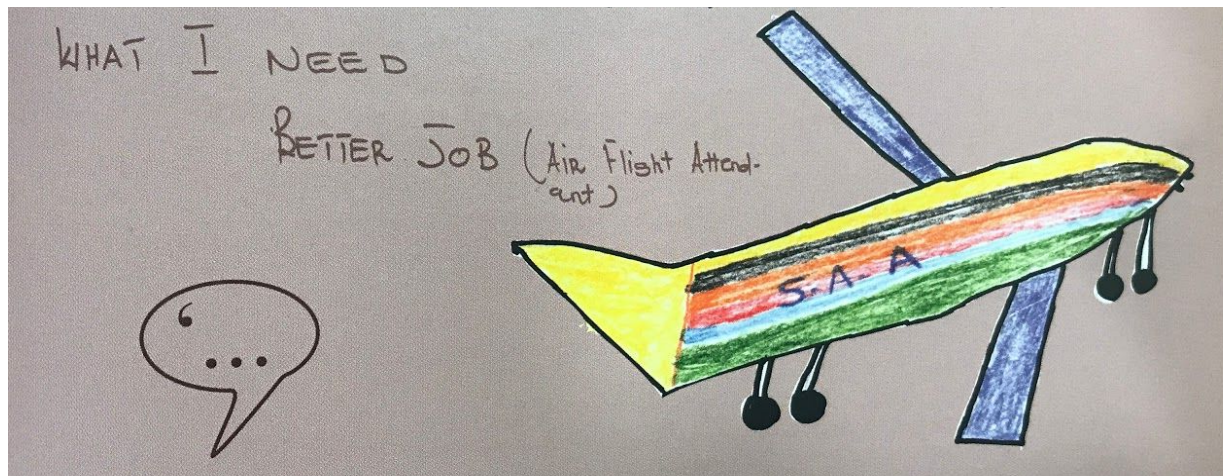


Figure 10. Bongiwe. (Morgan 2003)

Biomedicine can effectively prolong the lives of people with HIV, but it is not holistic. According to Biehl and Petryna the magic-bullet approach implements treatment regimes

without due consideration of the local infrastructure (2013). The administration of antiretrovirals performed in this context does not account for the complexity of the epidemic; magic-bullets assume stagnant relationships as they rely on scientific fact. Improvements on the surface do not mend the broken core. The magic-bullet, pharmaceutical drugs, neglects the ailing factors that rest outside the biological sphere. ARVs did not treat the violence behind Bongiwe's scars. Another non-biological factor, depicted in several body maps and self-portraits, is unemployment. In Figure 10, Bongiwe illustrates her desire for better employment, to be a flight attendant.

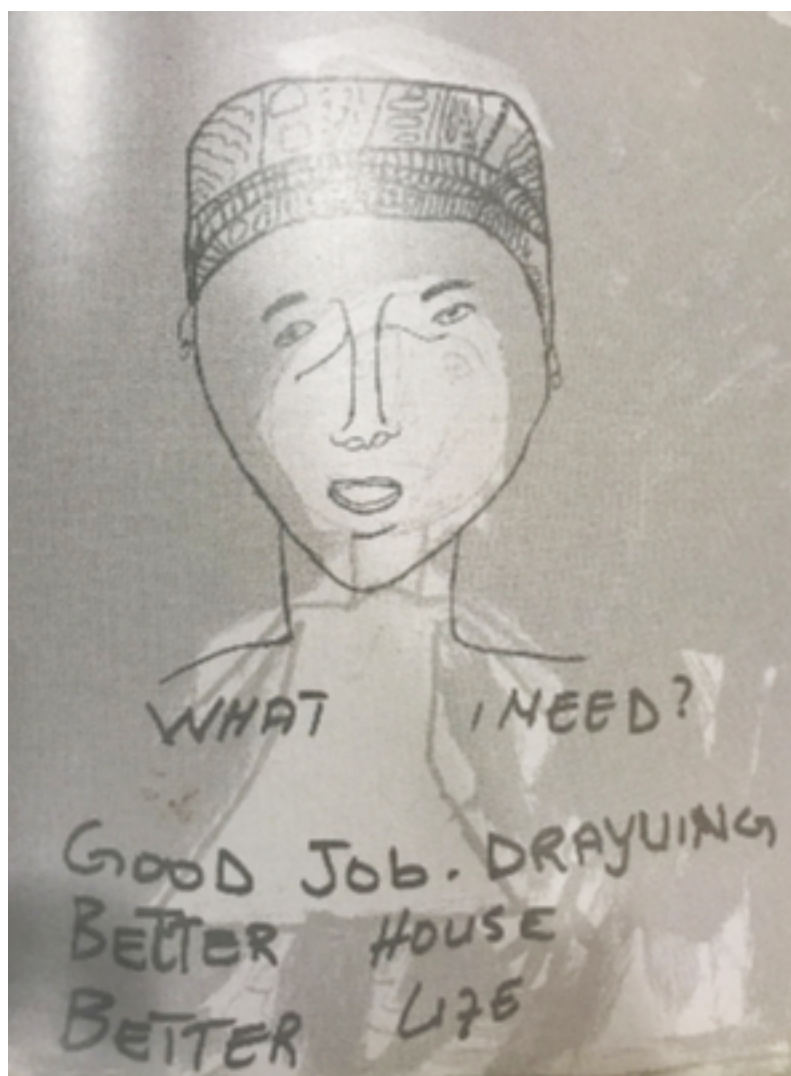


Figure 11. Thozama. (Morgan 2003)

Thozama, another woman in the support group, illustrates similar desires in Figure 11 by stating: “What I need? Good job. Drawing. Better House Better Life.” (Morgan 2003, 97). Despite ARV treatment to relieve HIV symptoms, these women are still suffering the symptoms of poverty. Former President Mbeki’s claim that poverty caused AIDS can be re-assessed through this lens. Economic hardships stemming from the past continue to influence modern life. President Mbeki, however, overshot his claims by completely neglecting the biomedical perspective. The incorporation of biomedicine, into his socio-economic reform, as treatment would have saved countless lives while recognizing entanglements. Appearing as if a reflection of Mr. Ali (Levine 2015), living in apartheid, these women are systematically restrained from progress by structural violence.

Body Maps as an Intersection of Biomedicine and Witchcraft

Nondumiso was born in 1975 in Cape Town. She was diagnosed with HIV when she was twenty-five years old. Nondumiso describes the overwhelming feeling of this diagnosis; she felt bombarded by the tests and questions of the medical staff. She only initially confided her status to her brother, who is also HIV-positive. After telling her mother, her mother claimed that “a witchdoctor in Transkei told her that all her children were going to be sick, but he never told her which disease they would have” (Morgan 2003, 39). The application of witchcraft normalizes the prevalence of the disease. The blame, in the mother’s eyes, rests among the witches, not her children; it shifts moral responsibility.

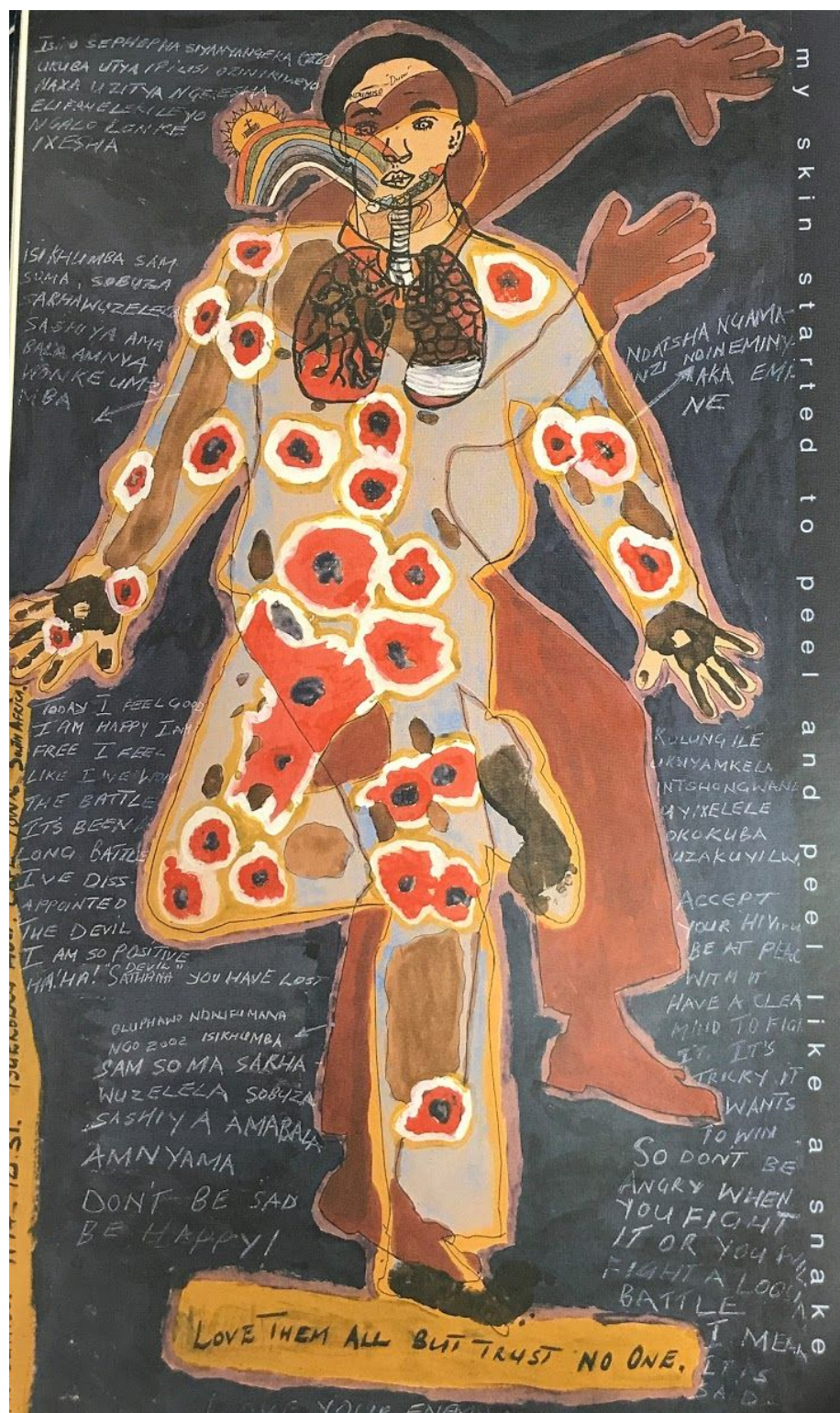


Figure 12. Nondumiso. Body Map. (Morgan 2003)

Nondumiso is not sure how she contracted the virus but suspects from an ex-boyfriend, she makes this assumption based on his current frail state. She describes: “Maybe he knew and he did it on purpose, because he didn’t tell me. But anyway, I cannot blame him. I can blame myself for not using a condom” (Morgan 2003, 40). Created as a HIV victim, Nondumiso assumes responsibility for the disease. The dichotomy of blame, between Nondumiso and her mother, shows the current clash of biomedicine and social discourse in South African medicine. Nondumiso blames herself; her mother blames witchcraft. Victim blaming (biomedical understanding) neglects the vast networks that contribute to transmission, dismissing contributing sexual networks enables their continuation. Witchcraft places the disease in context the larger social framework, looking into the entanglements that may render one susceptible to witchcraft and/or cause one to become bewitched. The body is understood in two seemingly contrasting perspectives: an individual being and as part of a greater system.

The body is a key component to both the AIDS epidemic and the epidemic of the social as it serves a social and biological functions. Personal identity and social relationships develop alongside biological systems. Bodies are part of social systems as they engage in larger networks with other people, places and things. Achieving biological visibility can often be achieved by professional diagnosis; social visibility is achieved by acceptance in social norms. Body maps illustrate the entanglement of the HIV/AIDS epidemic and the epidemic of the social (Thomas 2013; Morgan 2003). Biomedicine is an oversimplification of an amorphous world as it assumes static truths, and neglects entanglements (Read 1980). The conglomeration of the body, as both an individual site and one that rests within is a greater system, would benefit HIV/AIDS treatment.

HIV and AIDS are labels of biological dysfunction. Awareness campaigns, testing programs, and the implementation of pharmaceutical drugs implement biomedical discourse to combat the HIV/AIDS epidemic. Limitations in these methods derive from their ignorance of the coinciding social crisis. It must be realized that multiple truths can simultaneously exist, for example, witchcraft.

Ignorance towards the Other: Witchcraft and Traditional Healing in South Africa

We [the black consciousness movement] do not reject it [witchcraft]. We regard it as part of the mystery of our cultural heritage... Whites are not superstitious; whites do not have witches and witch doctors. We are the people who have this. (Biko cited in Niehaus 2001, 183).

The politically sanctioned violence of Apartheid was camouflaged during the 1994 political transition; it lives on under the guise of structural violence. Didier Fassin states that AIDS can illuminate the “often invisible or obscured realities of the social world, prejudices, tensions, and power relations that already existed but we not perceived at the time” (2007, 17). This results from looking into the gaps left by biomedical limitations. As biomedicine works through pathways of visibility, it neglects influential factors that lie among the invisible. The legacy of apartheid lives through structures of continued oppression. The burdens placed on black South Africans, dating back to the seventeenth century colonization, form the base from which the modern nation rests. European powers, predominantly the Dutch, systematically fragmented native populations. The emergent economy, dependent on slave-wage labor, contributes to the present economic hardships.

While the post-Apartheid transition was internationally commended, it failed to heal countless wounds of the past. The Truth and Reconciliation Commission (TRC) was a form of

restorative justice. It was used to investigate, and heal from, the horrors of Apartheid. This attempt at closure sought to address the past in order to separate it from the present. Rosemary Nagy suggests that the South African TRC denied the continuation of apartheid-induced violence (2012). Instead, it attempted to compartmentalize time. The past was recognized as independent from the present. It could thus be isolated and thrown away in order to build the new South Africa, from the present, and for the future. Neglecting temporal entanglements, in the TRC and additional national reforms, resulted in the once visible violence of the NP transitioning underground. The resulting structural violence lay at the base from which the new South Africa rose. It became invisible, yet ever present. The resulting social crisis created a space vulnerable to the influx of witchcraft.

The hope accompanying the democratic transition was never met. Resulting disappointment furthered social conflict (Ashforth 2000). A new black elite emerged while the majority remained subjected to harsh realities. In a conversation with Madumo, Ashforth accounts the belief that “Freedom and democracy have caused the increased witchcraft because they’ve led to more jealousy” (2000, 100). The reciprocity that once existed among neighbors was shattered. The NP harnessed the power of spatiality to systematically fragment black South Africans; post-apartheid attempts to reconfigure power resulted in fragmentation by those that could and those that could not restore such spaces (Kihato 2014). The economic structure, created to support a white minority through the exploitation of the majority population, was not built for majority control. Therefore, only a minority of the previously oppressed black population had the ability to reconfigure this power. In these disparities, the social crisis thrives as a plethora of dreams were lost to an ill-equipped national infrastructure (Kihato 2014).

Witchcraft is a complex phenomenon that thrives in the gaps of biomedicine, in instances of social fragmentation. Witchcraft holds invisible power and renders visible effects (Fassin 2007; Niehaus 2001). While the role of witchcraft in the social ought not to be restricted, this thesis will situate it as a way of life that enables us to view the social crisis through its discourse.

Evans-Pritchard defined witchcraft as “a framework of moral agency that can make sense of seemingly random coincidences in space and time” (1976, 69). This explains how the Azande acknowledge natural phenomena and separate sociological occurrences. They realize these happen independently but seek to explain their interdependence. This etic definition provides a general idea of witchcraft that describes its ability to answer the question: “why me?” Witchcraft existed in South Africa long before the introduction of HIV. It has deep roots in South African society as it continues to evolve over time and space. Apartheid implemented laws, such as the Suppression of Witchcraft Act in 1957, aimed to rid such practices. However, the prevalence of witchcraft escalated (Niehaus 2001). Ashforth defines witchcraft as “the manipulation by malicious individuals of powers ... to cause harm to others” (2002, 126). This emic definition comes from ethnographic field work in the Bushbuckridge region of South Africa; it provides a greater localized understanding of witchcraft. As a complex and fluid discourse, witchcraft cannot be constrained to a set definition. This thesis will implement these definitions as a general framework to understand local accounts of witchcraft.

Witchcraft has the ability to allocate blame and offer a deeper understanding of unwanted ambiguity. Instances of witchcraft increased after South African independence in 1994 (Ashforth 2000). As demonstrated above, post-Apartheid society faced many instances of fragmentation.

Free from the handcuffs of the NP, black South Africans were granted the right to freely participate in society. This democratic freedom increased competition within the black population who were now bound by the forces of structural violence (Farmer 2003; Ashforth 2000).

Isidliso is the most common form of witchcraft associated with HIV/AIDS in South Africa (Ashforth 2002). Ashforth states, “*Isidliso* slowly consumes its victim, creating all manners of hardship and pain along the way, such as friendship breaking, lovers leaving or jobs disappearing” (2002, 130). It contributes to both social and biological ailments. Treating these ailments requires a traditional healer. These instances show how witchcraft exists in daily life, and its reality among the social crisis can shape responses to HIV/AIDS. As an ambiguous yet common practice, witchcraft works in the shadows but lives in daily life. Ethnographic fieldwork in South Africa and anthropological theory will be used to illustrate the social crisis, and entanglements with the HIV/AIDS epidemic, through witchcraft discourse. (Dickinson 2013; Henderson 2011; Stadler 2003; Ashforth 2002; Ashforth 2000).

Ntuthuko Hadebe (Henderson 2011)

Numerous certificates of achievement are mounted on the walls of Ntuthuko Hadebe’s medicine shop. Ntuthuko is an inyanga, a traditional healer, like his grandfather before him. He turned to this profession after experiencing sickness, familial conflict, and death, in hopes of finding a solution. Henderson describes Ntuthuko’s story as a journey, as it involves constant interpretation and movement (2011). This practice of traditional healing traced maladies to determine causes, and treatments. It connected time and space to configure a present in regards to the past, present, and future.

Traveling is the prevailing theme of this narrative. This is interesting as it falls within context of Apartheid's strict laws regulating travel. A state issued passbook was required to travel, and movement was limited. These passbooks have roots tracing back to slavery; they were created to control the movement of slaves in the 18th century (Microsoft Online Encyclopedia 2000). This was a method of containment. People had to move for work, but were only allowed to do this for one year at a time (after which they would have to return to their given home region and then repeat the process). Relationships between friends and family members were difficult to maintain. The NP fragmented the black majority in order to sustain their oppression- to reduce the opportunity for collective resistance. Born in 1948, Ntuthuko was subjected to such regulations from birth.

Ntuthuko worked as a plasterer and taxi driver, in addition to being an inyanga. He traveled across the country (albeit for a small period), absorbing knowledge from the people, places, and things he encountered along the way. Ntuthuko learned to understand the roads of the earth, the water and the sky- his acquisition spanned beyond the profane. Latour's natures-cultures is exemplified in this entanglement (1993). Ntuthuko transcended beyond the limitations prescribed in apartheid. He was able to relocate autonomy as he bypassed federal prohibition; it was a form of creative opposition. (Henderson 2011).

Ntuthuko's journey narrative is symbolic of inyanga practices, as a traditional healer works in a situational context to form their understanding of sickness. Ntuthuko said that actively paying attention to his surroundings greatly contributed to his practice. He remained open to new interpretations. His journey as an inyanga stands in contrast to the stagnant practice of a biomedical doctor. Biomedicine is planar, while witchcraft and inyangas are multidimensional.

Static attempts by Global Health to combat such traditional discourses continue to fail, as they do not recognize this dimensionality with their ‘universality.’ Traditional healing relates various dimensions in order to understand the present moment; biomedical practices stems from only the present moment.

Analysis of traditional healing experiences connects to Bongiwe, and body maps (Thomas 2013; Morgan 2003). Fire, as depicted by Bongiwe (Figure 9), can be understood within a broader local context to tell a different story. Bongiwe describes the fire as the virus, HIV. An element of nature, the inclusion of fire in this body map draws nature into the HIV/AIDS epidemic. Ntuthuko made frequent connections to nature in his journey as an inyanga (Henderson 2011). While Bongiwe was already receiving medication, she chose to still include the burning fire. The remaining flames may burn as a result of the social crisis. The ARVs treated the biological illness but failed to address the social inequalities, such as violence against women and unemployment, that contribute to its prevalence. The fire represents the social components of HIV.

The journey of an inyanga exemplifies the entanglements of the social crisis. As demonstrated by Alex Nading, in regards to Dengue fever in Nicaragua (2014), the trails between humans and non-humans, between people, places and things, have indisputable effects on local reality as they reassemble the social. The social realm lays void without the entanglements it embodies; society only exists in terms of such connections (Nading 2014; Latour 1993). This case study connects the social crisis and HIV/AIDS epidemic by contrasting the practices of traditional healing and biomedicine, in order to show how they can supplement the other.

Reggie Ngobeni (Niehaus 2013)

Reggie Ngobeni was born in a rural village of the Bushbuckridge region in 1961. After his father died in 1966, his paternal kin accused Reggie's mother of witchcraft. As a result, the family was forced to relocate. They moved in with extended maternal kin. Reggie went to school for six years before dropping out due to financial restraints. His family often struggled to attain adequate food and clothing. Despite instances of malnutrition, Reggie was a relatively healthy child. The only sickness he recalls are stomach pains, which started when he was nineteen years old.

As an adult, Reggie moved to Johannesburg to work as a repairman at a mining company. There, he fell in love with a Swazi woman named Zanele. Reggie experiences relatively good fortune in Johannesburg for seven years, until he lost his job and Zanele left him for another man. Working as a security guard, Reggie was violently attacked on numerous occasions. As these hardships unfolded, Reggie began to fall sick. Reggie consulted a traditional diviner and a Christian healer in hopes of treating these social misfortunes (which he believed were the cause of his sickness). Their treatments of animal sacrifice and symbolic egg washing only provided temporary relief as two years later, Reggie was again unemployed and sick. This time, Reggie believed his affliction was the result of witchcraft. His prolonged separation from family angered his ancestors and left his body weak and susceptible to sickness. He soon reunited with his family Impalahoek in hopes of recovering.

Reggie was eager to identify the underlying cause of his disease. He grew suspicious of various possible sources of this witchcraft. Afisi, his sister in law, "insisted that Ndzau spirits were calling him to become a diviner. These spirits, she said, always strike the stomach" (359).

While much literature discusses the fragmentation of kinship in South Africa as a result of forced relocation under Apartheid, these systems remain stable for Reggie. McNeill describes the resurgence of such values as a result of Mbeki's African Renaissance (2009). Numerous local chiefs used Mbeki's movement to regain power and reinstitute many traditional values, such as kinship ties. Reggie soon began his divination training (a financially straining practice). As his health deteriorated, Reggie questioned the legitimacy of his instructor. He describes his new attitude and their interactions afterwards:

I no longer trusted my instructor. She treated me badly. She said that because I did not want to dance, I should pay her and go home. She still wanted R3000. She said if I did not pay her, AIDS would attack me. I cried when she said those painful words (Niehaus 360).

After paying the remainder of the fees, Reggie ended his training. His sickness continued to progress, eventually rendering him immobile. This caused his brother to take him to the hospital where he was diagnosed with HIV. He recounts his experience with the hospital staff:

When I first went to Rixile they [presumably nurses] took blood from the second finger of my right hand. Then they said I had HIV and that my CD4 count was 94. [...] They did not tell me from where I got the AIDS. But they said that I must not sleep with a woman without a condom. I must also not kiss someone with sores on the mouth. They also told me not to touch anybody when I am bleeding, and that I must wear gloves if I touch someone who is bleeding at an accident. The AIDS will jump. It can come to you with a scratch or a cut (Niehaus 361).

After initial reluctance, Reggie accepted the prognosis. He, however, did not accept the supposed theory of disease causation. Reggie did not believe that HIV was sexually transmitted because he only had sex with "good looking and clean ones [women]" (Niehaus 2013, 361). This lay theory illustrates the complexity of disease perception within the epidemic. Ambiguity in biomedical discourse rendered great insecurity in regards to visibility. HIV tests could state a result but were unable to provide the path to such a diagnosis. In this invisibility, alternative understandings

prevailed. He instead blamed his divination instructor; her threat caused his disease. It is often believed that those in position of authority hold great power in their words. Reggie's disputes with his instructor provide insight into local power relations as it is dangerous to question authority. This intimidation, similar to the fear produced in public art, can result in silence.

Reggie further doubted the sexual transmission of HIV on the basis that he had similar symptoms before becoming sexually active- referring to the stomach pains when he was nineteen years old. As symptoms are often not unique to a single illness, the validity of diagnosis is questioned. He continued to take his prescribed ARV tablets due to the fear inscribed by the hospital stagg: "They told me never to forget to take the tablets, and always to drink them at the right time. Otherwise the tablets won't work. If I only miss one day I'll die" (Niehaus 2013, 361). The use of fear in treatment discourse is again creating the disease as a mystical, all-powerful, object. This illustrates adherence, rather than acceptance. The dismissal of HIV, as described by biomedical discourse, enabled Reggie to diminish stigma and maintain personal authority. He regards himself as the victim of witchcraft rather than the AIDS victim. The former situates the blame in social networks, while the latter attributes the blame of disease acquisition to the person afflicted. Accepting a HIV diagnosis is associated with accepting blame and additional social consequences. Exploring alternative explanations, as done by Reggie, is a way to diminish social consequences as association with disease is left ambiguous. This narrative can provide a critique of President Zuma's testing campaign as it would situate the blame with the individual and neglect the alternative understandings of disease transmission.

In a dream, Reggie's ancestors told him to go to the Zion Christian Church in order to supplement his recovery. Reggie gives credit to the church for solidifying his initial treatment: "I

only became better after I went to church and took their prescriptions. Now I can walk and I can run.” (Niehaus 2013, 362). The church and medicine were complementary to his recovery. The role of his ancestors is monumental in Reggie’s story. The evident intersection of various forms of being, such as the form one takes from death, stands in contrast to biomedicine and the value it places on life. The instances of fear depicted in biomedical awareness murals (Figure 8), neglect this connection between generations, alive or dead, that continue to impact the epidemic.

Reggie’s story is an example of how pharmaceutical drugs “might cure the illness, but unless the witchcraft that lays one open to illness is removed, and protection secured against whatever further affliction might be dispatched by those responsible, curing the illness alone is merely treating the symptom, not the cause” (Ashforth 2000, 62). The ARV tablets are able to treat the biological agents of HIV, while the Church “complemented medication by providing much needed social support, and powerful religious rationale for health maintenance” (Niehaus 2013, 363). Reggie used numerous treatments throughout this story. It was only when working in conjunction with one another did they yield adequate results.

Entanglements of the Epidemics: Concluding remarks

The HIV/AIDS epidemic and the social crisis are entangled in South Africa. Current health practices fail to recognize that these crises exist simultaneously. Global health as a universal paradigm relies on technicalities, to the disregard of the practical implications. Traditional healing, and witchcraft, portray entanglements in their practice but do so to the demise of biomedicine, often failing to incorporate the benefits of western medical advances. The stagnation of biomedicine ought to be supplemented by the flows of witchcraft, religion, and traditional healing, and vice versa.

The present can not exist in isolation of the past. The temporal entanglements of South Africa connects the HIV/AIDS epidemic to the structural violence in post-apartheid society. Failure to recognize these underlying structures contributes to its proliferation. The reconfiguration of a ‘geographically broad’ and ‘historically deep’ Global Health could provide a more holistic treatment regimen (accounting for both social and biological factors) for HIV/AIDS (Farmer 2003).

There are only natures-cultures, the HIV/AIDS epidemic only exists in relation to the social crisis. In this view, there is no purely biomedical model of health as it is defined today. The attempt to establish Global Health separate from the social crisis dramatically weakens its application. Understanding medicine as sociocultural requires acknowledgement of the entanglement of human and non-human elements that transcend past the western-made border between the profane and sacred, life and death, heresy and sanity, nature and culture. The networks of translation (Figure 5) break the border between ‘us’ and ‘them.’ This can allow for greater social reform as it treats the fragmentation between the diverse ethnicities within South Africa. There are multiple correct perceptions of the world, which intersect to create an ever-changing reality.

In its failure to implement symmetrical practices, global health strengthens HIV/AIDS and furthers the epidemic. Embedded structures negate attempts at progress across South Africa. The social crisis and HIV/AIDS epidemic, and all associated discourses, must be understood with equal importance. Treatment programs for the epidemic, and the social crisis, exist. Their convergence is necessary in order to yield more adequate results. Converging treatment, with the

additional recognition of the continued structural violence, could transform the South African HIV/AIDS epidemic for the better.

Bibliography

Adelman, Erica. 2008. "Strength in the Midst of Loss and Despair: HIV/AIDS and the Growing Numbers of Orphans in South Africa, 1982-2008." Senior Honors Thesis. Appalachian State University.

African National Congress. Provisional Committee of the African National Congress Youth League. March 1944. *ANC Youth League Manifesto*. Web.
<https://www.sahistory.org.za/archive/anc-youth-league-manifesto-1944> (accessed April 25, 2019)

Ashforth, Adam. 2000. *Madumo: A Man Bewitched*. Chicago: University of Chicago Press.

□. 2002. "An Epidemic of Witchcraft? The Implications of AIDS for the Post-Apartheid State." *African Studies* 61 (1): 121-143.

Avert. 2018. "Sex Workers, HIV and AIDS." Accessed 6 May, 2019.

<https://www.avert.org/professionals/hiv-social-issues/key-affected-populations/sex-workers>

□. 2019. "HIV and AIDS in South Africa." Accessed February 10, 2019.

<https://www.avert.org/professionals/hiv-around-world/sub-saharan-africa/south-africa>.

Biehl, Joao and Adriana Petryna. 2013. *When People Come First: Critical Studies in Global Health*. Princeton: Princeton University Press.

Campbell, Catherine, Carol Foulis, Sbongile Maimane, and Zweni Sibiya. 2005. "'I Have an Evil Child at My House': Stigma and HIV/AIDS Management in a South African Community." *American Journal of Public Health* 95, no. 5: 808-15.
<https://doi:10.2105/AJPH.2003.037499>.

- Christie, Pam and Colin Collins. 1982. "Bantu Education: Apartheid Ideology or Labour Reproduction?" *Comparative Education* 18 (1): 59-75.
- Congress of the People. *Freedom Charter*. Johannesburg: June 1955. From University of Witwatersrand, *Inventories of Historical Papers*. Web.
http://www.historicalpapers.wits.ac.za/inventories/inv_pdfo/AD1137/AD1137-Ea6-1-001-jpeg.pdf (accessed April 25, 2019).
- Dickinson, David. 2013. "Myths or Theories? Alternative Beliefs about HIV and AIDS in South African Working Class Communities." *African Journal of AIDS Research* 12 (3): 121-130.
- Elmore, Kimberlee. 1996. "Geographical Diffusion of AIDS Among Women in North Carolina: 1987-1993. Masters Thesis. Appalachian State University.
- Evans-Pritchard, E. E. 1976. *Witchcraft, Oracles, and Magic among the Azande*. Oxford: Clarendon Press.
- IJsselmuiden, C, C Evian, J Matjilla, M Steinberg, and H Schneider. 1993. "AIDS in South Africa." *AIDS & Society* 4 (2): 1.
- Farmer, Paul. 2003. *Pathologies of Power: Health, Human Rights, and the New War on the Poor*. Berkeley and Los Angeles: University of California Press.
- Fassin, Didier. 2007. *When Bodies Remember: Experiences and Politics of AIDS in South Africa*. Translated by Amy Jacobs and Gabrielle Varro. Berkeley: University of California Press.
- Foucault, Michel. 1926. *The History of Sexuality*. New York: Pantheon Books, 1978.
- . 1979. "What is an Author?" *Screen* 20, no. 1: 13-34.
- . 2003. *The Birth of the Clinic*. London: Routledge.

- Heffernan, Anne and Noor Nieftagodien. 2016. *Student Must Rise: Youth Struggle in South Africa Before and Beyond Soweto '76*. Johannesburg: Wits University Press.
- Henderson, Patricia. 2011. *AIDS, Intimacy and Care in Rural KwaZulu-Natal: A Kinship of Bones*. Amsterdam: Amsterdam University Press.
- History.com editors. 2009. "Nelson Mandela." The History Channel. Last modified November 9, 2009. <https://www.history.com/topics/africa/nelson-mandela>.
- Kalichman, SC, L Eaton, and C Cherry. 2010. "There Is No Proof That HIV Causes AIDS': AIDS Denialism Beliefs Among People Living with HIV/AIDS." *Journal of Behavioral Medicine* 33 (6): 432-440.
- Karim, Quarraisha and Salim Karim. 2002. "The Evolving HIV Epidemic in South Africa." *International Journal of Epidemiology* 31 (1): 37-40.
- Kekana, Mashadi. 2019. "Slight Drop in Unemployment Rate at End of 2018- Stats SA." Accessed May 6, 2019. <https://mg.co.za/article/2019-02-13-national-unemployment-rate-dropped-slightly-at-end-of-2018-stats-sa>
- Kihato, Carolina. 2014. "Lost Dreams? Tales of the South African City Twenty Years After Apartheid." *African Identities* 12: 357-370.
- Latour, Bruno. 1993. *We Have Never Been Modern*. Cambridge: Harvard University Press.
- Levine, Janet. 2015. *Inside Apartheid: One Woman's Struggle in South Africa*. Newbury: Open Road Distribution. ProQuest Ebook Central.
- Mandela, Nelson. 1964. "I Am Prepared to Die." Rivonia Trial: Pretoria Supreme Court. Speech. Accessed April 1, 2019.

<https://www.sahistory.org.za/archive/i-am-prepared-die-nelson-mandelas-statement-dock-opening-defence-case-rivonia-trial-pretoria>

Marschall, Sabine. 2004. "Getting the Message Across: Art and Craft in the Service of HIV/AIDS Awareness in South Africa." *Visual Anthropology* 17: 163-182.

Mbeki, Thabo. 1998. "African Renaissance, South Africa, and the World." United Nations University. Speech. Accessed February 19, 2019.

<http://archive.unu.edu/unupress/mbeki.html>

McNeill, Fraser. 2009. "'Condoms Cause AIDS': Poison, Prevention and Denial in Venda, South Africa." *African Affairs* 108/434: 353-370.

Microsoft Online Encyclopedia. 2000. "Pass Laws." Accessed March 3, 2019.

<http://autocww.colorado.edu/~toldy3/E64ContentFiles/AfricanHistory/PassLaws.html>

Mogale, Ramadimetja, Kathy Burns and Solina Richter. 2012. "Violence Against Women in South Africa: Policy Position and Recommendations." *Violence Against Women* 18 (5): 580-594.

Morgan, Jonathan. 2003. *Long Life: Positive HIV Stories*. Cape Town: Double Storey; North Melbourne: Spinifex Press.

Nading, Alex. 2014. *Mosquito Trails: Ecology, Health, and Politics of Entanglement*. Oakland: University of California Press.

Nagy, Rosemary. 2012. "Truth, Reconciliation and Settler Denial: Specifying the Canada-South Africa Analogy." *Human Rights Review* 13 (3): 349-67.

Naidou, Kammila. n.d. "The War on Women and Children in South Africa." Accessed April 1, 2019.

<https://africasacountry.com/2019/01/the-war-on-women-and-children-in-south-africa>

Niehaus, Isak. 2013. *Witchcraft and a Life in the New South Africa*. New York: Cambridge University Press.

□. 2001. *Witchcraft, Power and Politics: Exploring the Occult in the South African Lowveld*. Cape Town: Pluto Press.

Ngcaweni, Busani. 2016. *Sizonqoba! Outliving AIDS in Southern Africa*. Pretoria: Africa Institute of South Africa.

Nguyen, Vinh-Kim. 2010. *The Republic of Therapy: Triage and Sovereignty in West Africa's Time of AIDS*. Durham: Duke University Press.

Obama, Barack. 2010. "Foreword." In *Conversations with Myself*, by Nelson Mandela. Auckland: PQ Blackwell Limited.

Packard, Randall. 2016. *A History of Global Health: Interventions into the Lives of Other Peoples*. Baltimore: Johns Hopkins University Press.

Powers, Theodore. 2017. "Knowledge Practices, Waves and Verticality: Tracing HIV/AIDS Activism from Late Apartheid to the Present in South Africa." *Critique of Anthropology* 37 (1): 27-46.

Pretorius, Fransjohan. "The Boer Wars." History. Last modified March 29, 2011.

https://www.bbc.co.uk/history/british/victorians/boer_wars_01.shtml

Read, Kenneth. 1980. *The High Valley*. Columbia University Press.

Reality Check Team. 2018. "South Africa Crime: Can the Country be Compared to a 'War Zone?'" Last modified September 18, 2018.

<https://www.bbc.com/news/world-africa-45547975>

Redfield, Peter. 2013. *Life in Crisis: The Ethical Journey of Doctors Without Borders*. Berkeley: University of California Press.

Ross, Robert. 1999. *A Concise History of South Africa*. Cambridge: Cambridge University Press.

South African History Online. 2016. "A History of Apartheid in South Africa." Accessed February 10, 2019. <https://www.sahistory.org.za/article/history-apartheid-south-africa>.

South Africa National Planning Commission. Statistics South Africa. *Statistical Release: Mid-year Population Estimates*. Pretoria, 2018.

□. *Crime Statistics Series Volume 5: Crime against Women in South Africa*. Pretoria, 2018.

South Africa Public and Media Relations. *Quarterly Labour Force Survey: Quarter 4: 2018*. Pretoria: StatsSA, 2019. Accessed May 6, 2019.

<http://www.statssa.gov.za/publications/P0211/P02114thQuarter2018.pdf>

Stadler, Jonathan. 2003. "Rumor, Gossip and Blame: Implications for HIV/AIDS Prevention in the South African Lowveld." *AIDS Education Prevention* 15 (4): 357-368.

□. "The Young, the Rich, and the Beautiful: Secrecy, Suspicion and Discourses of AIDS in the South African Lowveld." *African Journal of AIDS Research* 2 (2): 127-139.

Street, Alice. 2014. *Biomedicine in an Unstable Place: Infrastructure and Personhood in a Papua New Guinean Hospital*. Duke University Press.

The Age of AIDS. 2006. Boston: WGBH Educational Foundation.

The AIDS Institute. 2011. "Where did HIV come from?" Accessed April 19, 2019.

<https://www.theaidsinstitute.org/education/aids-101/where-did-hiv-come-0>.

The Open University. 2012. "What is biomedicine?" Accessed March 18, 2019.

<https://www.open.edu/openlearn/body-mind/health/health-studies/what-biomedicine>.

Thomas, Kylie. 2013. *Impossible Mourning: HIV/AIDS and Visuality After Apartheid*. Lanham: Bucknell University Press.

Treatment Action Campaign. n.d. "About." Accessed April 30, 2019.

<https://tac.org.za/category/about/>

□. 2000s. HIV/AIDS Treatment Plan Now. From Northwestern University,

<https://images.northwestern.edu/multiresimages/inu:dil-70570982-8366-4038-81c5-1d8a10094490>

Turok, Ivan and Jackie Borel-Saladin. 2016. "Backyard Shacks, Informality and the Urban Housing Crisis in South Africa: Stopgap or Prototype Solution?" *Housing Studies* 31 (4): 384-409.

Twalo, T. 2010. "Education for Self Reliance- South Africa's Alternative for Addressing Skills Shortage and Job Creation: A Literature Review." *South African Journal of Higher Education* 24 (5): 832-846.

U.S. Department of Health and Human Services. n.d. "How is HIV Transmitted?" Accessed April 19, 2019.

<https://www.hiv.gov/hiv-basics/overview/about-hiv-and-aids/how-is-hiv-transmitted>

World Health Organization. 2018. *Estimated Number of People Living with HIV, 2016*. [Map].

https://www.who.int/gho/hiv/epidemic_status/cases_all/en/